

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES  
SURVEY, CERTIFICATION AND CREDENTIALING COMMISSION  
INITIAL APPLICATION FOR ASSISTED LIVING AND RESIDENTIAL HEALTH CARE FACILITIES

PART I

The undersigned hereby applies to the Kansas Department for Aging and Disability Services for a license to operate an adult care home subject to the provisions of Kansas law.

"Applicants for adult care home licenses are reminded that K.S.A 39-938 and the Physical Environment or Construction K.A.R. for each respective adult care home require compliance with rules and regulations of the secretary of aging and the state fire marshal, and any other agency of government so far as pertinent and applicable to adult care homes, their buildings, operators, staffs, facilities, maintenance, operation, conduct, and the care and treatment of residents. To check for compliance with regulations and ordinances such as local building codes and zoning requirements, the owners and operators of adult care homes may wish to seek counsel from their attorney, architect, contractor, or other appropriate professional."

REASON (mark with "X")	<input type="checkbox"/> INITIAL	<input type="checkbox"/> CHANGE OF OWNERSHIP	<input type="checkbox"/> AMENDED
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A. Facility Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip (9-digit) \_\_\_\_\_ County \_\_\_\_\_

Telephone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Federal Tax ID # \_\_\_\_\_

B. **Administration**

Administrator's Name \_\_\_\_\_  
*(assisted living/residential health care of 61 or more residents)*

License/Registration No: \_\_\_\_\_

Administrator's Email \_\_\_\_\_

Operator's Name \_\_\_\_\_

Operator's Email \_\_\_\_\_

C. **License Category**

☐ Assisted Living Beds \_\_\_\_\_ ☐ Residential Health Care Beds \_\_\_\_\_ Total Number of Licensed beds \_\_\_\_\_

D. **Professional Liability Insurance Company**

Name of Professional Liability Insurance Co \_\_\_\_\_  
Amount of Professional Liability Insurance \$ \_\_\_\_\_

E. Name and address of Owner(s) of Building/Premises  
*(copy of deed must be attached when filing for "initial" or "change of ownership" application.)*

\_\_\_\_\_  
\_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone No. \_\_\_\_\_

F. Name and address of Lessee or Contract Purchaser

\_\_\_\_\_  
\_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone No. \_\_\_\_\_

G. Name and address of Sublessees

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Contact Person: \_\_\_\_\_ Telephone No. \_\_\_\_\_

H. Name and address of Management Firm who Operates Facility

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Contact Person: \_\_\_\_\_ Telephone No. \_\_\_\_\_

I. Name and address of any other Entities involved in the operation or management of the Adult Care Home

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J. Was the building financed by an industrial revenue bond? ☐ Yes ☐ No

If yes, give name and address of the government agency.

Expiration date of bonds: \_\_\_\_\_

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K. Attach completed Part II for each entity that appears on lines E, F, G or H.

L. Submit Fee

The fee to operate an Adult Care Home is \$100.00 plus \$30.00 for each bed. Payment shall be made payable to The Kansas Department for Aging and Disability Services. Please return completed form and payment to: Kansas Department for Aging and Disability Services, Survey, Certification and Credentialing Commission, 612 S. Kansas Ave, Topeka, Kansas 66603.

The undersigned is authorized to represent all licensees:

\_\_\_\_\_  
Signature and Title

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**DO NOT WRITE BELOW THIS LINE**

License Effective Date \_\_\_\_\_ License ID Number \_\_\_\_\_

License Status \_\_\_\_\_ Annual Report Due Date \_\_\_\_\_ Approved by \_\_\_\_\_

# KDADS SURVEY, CERTIFICATION AND CREDENTIALING COMMISSION

## PART II

- A. 

Facility Name	Address	City/Zip
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- B. Business Entity's Name \_\_\_\_\_
- C. Type of Entity    ☐ 1. Sole Proprietorship                      ☐ 2. Partnership                      ☐ 3. Joint Venture  
                                  ☐ 4. Corporation for profit                      ☐ 5. Corporation not-for-profit  
                                  ☐ 6. Government – Type \_\_\_\_\_ ☐ 7. Other (explain) \_\_\_\_\_  
                                  ☐ 8. Limited Liability Company
- D. Give the Resident Agent's name and address as filed/registered with the Secretary of State's Office for the business entity listed on Line B of this form. Contact the Secretary of State's Office at (785) 296-4564 to verify this information.

Resident Agent	Address
City	State                      Zip

Complete the boxes below with the information as follows for the business entity listed on Line B above.

1. List the name(s) and address(es) of each person who has any direct or indirect ownership of 5% or more in business entity listed above.
2. List each person who is the owner (in whole or in part) of any mortgage, deed or trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.
3. If the business entity is organized as a corporation, attach a list showing the names and addresses of each officer and director.
4. If the business entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 5% owner and for all general partners.
5. If the business entity is a government unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

INDICATE WITH "X"					INDIVIDUAL NAME	ADDRESS	CITY	STATE
1. OWNER	2. MORTGAGOR	3. DIRECTOR/OFFICER	4. LIMITED LIABILITY <i>Describe for each limited partnership and LLC the limited liability for each 5% owner and for all general partners.</i>	5. ELECTED OFFICIALS				

The following is the legal signature and title of the individual authorized to represent the governing body, corporation, partnership, joint venture, individual or organization in the operation of the facility by the business entity.

Signature and Title	Print Name	Date
Address		Phone Number